Introduction to Advance Health Care Directive

California law gives you the ability to insure that your health care wishes are known and considered if you become unable to make these decisions yourself.

The following are answers to commonly asked questions about Advance Health Care Directives.

What is an Advance Health Care Directive?

An Advance Health Care Directive is the best way to make sure that your health care wishes are known and considered if for any reason you are unable to speak for yourself. Completing a form called an "Advance Health Care Directive" allows you, under California law, to do either or both of two things:

First, you may appoint another person to be your health care "agent." This person (who may also be known as your "attorney-in-fact") will have legal authority to make decisions about your medical care if you become unable to make these decisions for yourself.

Second, you may write down your health care wishes in the Advance Health Care Directive form – for example, a desire not to receive treatment that only prolongs the dying process if you are terminally ill. Your doctor and your agent must follow your lawful instructions.

This form also allows you to express your wishes about organ and tissue donation.

Even though you do not have to appoint a health care agent, we recommend that you do so. Then there will be someone you trust to actively participate in the decisions surrounding your health care.

Is an Advance Health Care Directive different from a "living will"?

The Advance Health Care Directive is now the legally recognized format for a living will in California. It replaces the Natural Death Act Declaration. The Advance Health Care Directive allows you to do more than the traditional living will, which only states your desire not to receive life-sustaining treatment if you are terminally ill or permanently unconscious. An Advance Health Care Directive allows you to state your wishes about refusing or accepting life-sustaining treatment in any situation.

Unlike a living will, an Advance Health Care Directive also can be used to state your desires about your health care in any situation in which you are unable to make your own decisions, not just when you are in a coma or are terminally ill. In addition, an Advance Health Care Directive allows you to appoint someone you trust to speak for you when you are incapacitated.

You do not need a separate living will if you have already stated your wishes about life-sustaining treatment in an Advance Health Care Directive.

Is an Advance Health Care Directive different from a Durable Power of Attorney for Health Care"?

The Advance Health Care Directive has replaced the Durable Power of Attorney for Health Care (or "DPAHC") as the legally recognized document for appointing a health care agent in California.

What if I have already executed a Durable Power of Attorney for Health Care or a Natural Death Act Declaration? Is it still valid? Do I have to complete a new Advance Health Care Directive?

All valid Durable Powers of Attorney for Health Care (DPAHC) and Natural Death Act Declarations remain valid. Thus, unless your existing DPAHC has expired, you do not have to complete a new Advance Health Care Directive. A DPAHC executed before 1992 has expired and should be replaced.

Because the new Advance Health Care Directive gives you more flexibility to state your health care desires, you may wish to complete the new form even if you previously completed a DPAHC or Natural Death Act Declaration. At a minimum, you should review your existing DPAHC or Natural Death Act Declaration to make sure it has not expired and that it still accurately reflects your wishes.

Who can complete an Advance Health Care Directive?

Any California resident who is at least eighteen (18) years old (or is an emancipated minor), of sound mind, and acting of his or her own free will can complete a valid Advance Health Care Directive.

Do I need a lawyer to complete an Advance Health Care Directive?

No. You do not need a lawyer to assist you in completing an Advance Health Care Directive form. The only exception applies to individuals who have been involuntarily committed to a mental health facility who wish to appoint their conservator as their agent.

Who may I appoint as my health care agent?

You can appoint almost any adult to be your agent. You can choose a member of your family, such as your spouse or an adult child, a friend, or someone else you trust. You can also appoint one or more "alternate agents" in case the person you select as your health care agent is unavailable or unwilling to make a decision. (If you appoint your spouse and later get divorced, the Advance Health Care Directive remains valid, but your first alternate agent will become your agent.)

It is important that you talk to the people you plan to appoint to make sure they understand your wishes and agree to accept this responsibility. Your health care agent will be immune from liability so long as he or she acts in good faith.

The law prohibits you from choosing certain people to act as your agent(s). You may not choose your doctor, or a person who operates a community care facility (sometimes called a "board and care home") or a residential care facility in which you receive care. The law also prohibits you from appointing a person who works for the health facility in which you are being treated or the community care or residential care facility in which you receive care, unless that person is related to you by blood, marriage, or adoption, or is a co-worker.

Can I appoint more than one person to share the responsibility of being my health care agent?

We recommend that you name only one person as your health care agent. If two or more people are given equal authority and they disagree about a health care decision, one of the important purposes of the Advance Health Care Directive—to identify clearly who has authority to speak for you—will be defeated. If you are afraid of offending people close to you by choosing one over another to be your agent, ask them to decide among themselves who will be the agent, and list the others as alternate agents.

I want to provide more specific health care instructions than those included on this form. How do I do that?

You may write detailed instructions for your health care agent and physicians(s). To do so, simply attach one or more sheets of paper to the form, write your instructions, and sign and date the attachments at the same time you have the form witnessed or notarized.

How much authority will my health care agent have?

If you become unable to make your own health care decisions, your agent will have legal authority to speak for you in health care matters. Physicians and other health care professionals will look to your agent for decisions rather than to your next of kin or any other person. Your agent will be able to accept or refuse medical treatment, have access to your medical records,

and make decisions about donating your organs, authorizing an autopsy, and disposing of your body should you die.

If you do not want your agent to have certain of these powers or to make certain decisions, you can write a statement in the Advance Health Care Directive form limiting your agent's authority. In addition, the law says that your agent cannot authorize convulsive treatment (i.e., electroconvulsive therapy or ECT), psychosurgery, sterilization, abortion, or placement in a mental health treatment facility.

The person you appoint as your agent has no authority to make decisions for you until you are unable to make those decisions yourself, unless you choose to allow your agent to make those decisions for you immediately.

When you become incapacitated, your agent must make decisions that are consistent with any instructions you have written in the Advance Health Care Directive form or made known in other ways, such as by telling family members, friends or your doctor. If you have not made your wishes known, your agent must decide what is in your best interests, considering your personal values to the extent they are known.

What should I tell my family, my health care agent, and my doctors?

One of the most important parts of completing an Advance Health Care Directive is the conversations you have about it with your loved ones and your physicians. You should talk about your personal values and what makes living meaningful for you, your current medical condition and decisions you may foresee in the future; specific concerns or wishes you may have regarding life support or aggressive interventions, hospice or long-term care; what concerns you most about death or dying; and how you would want to spend the last month of your life. It is recommended, although not always possible, that such a discussion include both your physician(s), and your health care agent (and alternate agent(s)).

Tell your loved ones that you have completed an Advance Health Care Directive and what you have said in it, especially if you have selected a health care agent. Your Advance Health Care Directive will likely go into effect during a period of crisis for them. It can help ease their burden to know that you have made some of these decisions in advance. In addition, they should know in advance who is to speak for you in making medical decisions and where copies of your Advance Health Care Directive can be found. Remind them that their role is to make sure that your wishes are communicated and that those wishes guide their decision making.

Will my health care agent be responsible for my medical bills?

No, not unless that person would otherwise be responsible for your debts. The Advance Health Care Directive deals only with medical decision making and has no effect on financial responsibility for your health care. Please note, however, that unless you have made other arrangements, your agent may be responsible for costs related to the disposition of your body after you die. Consult an attorney regarding how your financial affairs should best be handled.

For how long is an Advance Health Care Directive valid?

An Advance Health Care Directive is valid forever, unless you revoke it or state in the form a specific date on which you want it to expire.

What should I do with the Advance Health Care Directive form after I fill it out?

Make sure that the form has been properly signed, dated, and either notarized or witnessed by two qualified individuals (the form includes instructions about who can and cannot be a witness). Keep the original in a safe place where your loved ones can find it quickly. Give copies of the completed form to the people you have appointed as your agent and alternate agent(s), to your doctor(s) and health plan, and to family members or anyone else who is likely to be called if there is a medical emergency. You should tell these people to present a copy of

the form at the request of your health care providers or emergency medical personnel.

Take a copy of the form with you if you are going to be admitted to a hospital, nursing home or other health care facility. Copies of the completed form can be relied upon by your agent and doctors as though they were the original.

Additionally, you may also wish to register your advance directive with the State of California voluntary Advance Health Care Directive Registry. The registration form and more information about the registry is available on the Secretary of State's website at www.sos.ca.gov/ahcdr.

What if I change my mind after completing an Advance Health Care Directive?

You can revoke or change an Advance Health Care Directive at any time. To revoke the entire form, including the appointment of your agent, you must inform your treating health care provider personally or in writing. Completing a new CMA Advance Health Care Directive will revoke all previous directives. In addition, if you revoke or change your directive, you should notify every person or facility that has a copy of your prior directive and provide them with a new one.

You should complete a new form if you want to name a different person as your agent or make other changes. However, if you need only to update the address or telephone numbers of your agent or alternate agent(s), you may write in the new information and initial and date the change. Of course, you should make copies or otherwise ensure that those who need this new contact information will have it.

Is my Advance Health Care Directive valid in other states?

An Advance Health Care Directive that meets the requirements of California law may or may not be honored in other states, but most states will recognize an Advance Health Care Directive that is executed legally in another state. If you spend a lot of time in another state, you may want to consult a doctor, lawyer, or the medical society in that state to find out about the laws there.

Can anyone force me to sign an Advance Health Care Directive?

No. The law specifically says that no one can require you to complete an Advance Health Care Directive before admitting you to a hospital or other health care facility, and no one can deny you health insurance because you choose not to complete an Advance Health Care Directive.

Advance Health Care Directive

(California Probate Code section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it.

You are free to use a different form

PART 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Receive and consent to the release of medical information.

(f) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

PART 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out PART 2 of this form.

PART 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

PART 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses OR acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institutions at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Advance Health Care Directive

(California Probate Code section 4701)

PART 1 Power of Attorney For Health Care

1.1 DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____
(Name of individual you choose as agent)

_____
(Address/City/State/Zip Code)

( ) _____ ( ) _____
(Home Phone) (Work Phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate the following as alternate agents in the order indicated:

_____
(Name of individual you choose as first alternate agent)

_____
(Address/City/State/Zip Code)

( ) _____ ( ) _____
(Home Phone) (Work Phone)

_____
(Name of individual you choose as second alternate agent)

_____
(Address/City/State/Zip Code)

( ) _____ ( ) _____
(Home Phone) (Work Phone)

1.2 AGENT'S AUTHORITY AND OBLIGATION: My agent is authorized to make all health care decisions for me, in accordance with this power of attorney, any instruction in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interests. In determining my best interests, my agent shall consider my personal values to the extent known to my agent.

My agent shall have the right to:

A. Consent, refuse consent, or withdraw consent to any medical care or services, such as tests, drugs or surgery, for any physical or mental condition. This includes the provision, withholding or withdrawal of artificial nutrition and hydration (tube feeding) and all other forms of health care, including cardiopulmonary resuscitations (CPR).

B. Choose or reject my physician, other health care professionals or health care facilities.

C. Receive my medical information and restrict any other person's right to use or distribute my medical information.

D. Consent to the release of my health care information. This release shall apply to any of my information that is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and California law. I intend my agent to be dealt with by all my health providers in the exact same way I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

E. Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, or health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition.

F. My agent is authorized to disclose all such information to any individual who is granted the power or authority to inquire into or issue an opinion regarding my capacity to act in any trust or power of attorney signed by me and to any court that is engaged in a determination of my capacity to act as fiduciary, or my capacity to manage my own personal or financial affairs. If my agent believes that the authority that I have granted in this paragraph is insufficient to accomplish the goals that my agent wishes to accomplish, my agent may seek court authority for greater access to, or greater ability to use and/or disseminate my medical information.

G. This authority has no expiration date and shall expire only if I revoke this authorization at any time by written notice to my health care provider. This authority shall supersede any prior agreement I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

1.3 WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician, or another physician treating me at the time, determines that I am unable to make my own health care decisions unless I mark the following box.

If I mark this box ☐, my agent's authority to make health care decisions for me takes effect immediately.

1.4 NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2 Instructions for Health Care ***If you fill out this part of the form, you may strike any wording you do not want.***

2.1 END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) **CHOICE NOT TO PROLONG LIFE**—I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, or

☐ (b) **CHOICE TO PROLONG LIFE**—I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2 RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed.)

2.3 OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed.)

PART 3 Agent's Post Death Authority

3.1 My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in part 3.2 below:

_____

_____

(Add additional sheets if needed.)

3.2 DONATION OF ORGANS AT DEATH (optional)

Upon my death (mark applicable box):

☐ (a) I give my needed organs, tissues, or parts, OR

☐ (b) I give the following organs, tissues, or parts only:

_____

(Add additional sheets if needed.)

☐ (c) My gift is for the following purposes (strike any of the following you do not want):

_ (1) Transplant
_ (2) Therapy
_ (3) Research
_ (4) Education

PART 4 Primary Physician (optional)

4.1 I designate the following physician as my primary physician:

_____
(Name of Physician)

_____
(Address/City/State/Zip Code)

_____
(Phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(Name of Physician)

_____
(Address/City/State/Zip Code)

(_____) _____
(Phone)

PART 5 PRIOR DIRECTIVES REVOKED:

I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration signed by me.

PART 6

6.1 EFFECT OF COPY: A copy of this form has the same effect as the original.

6.2 SIGNATURE: Sign and date the form here:

DATED:_____

_____ _____
Sign your name) (Address)

_____ _____
(Print your name) (City/State/Zip Code)

6.3 ACKNOWLEDGEMENT BY NOTARY PUBLIC:

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of)

On _____, before me, _____, *a Notary Public,* personally appeared _____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

6.4 STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

_____ _____

(Print Name) (Address)

_____

(City/State/Zip Code)

SECOND WITNESS

_____ _____

(Print Name) (Address)

_____

(City/State/Zip Code)

6.5 ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____

(Signature of Witness)

_____

(Signature of Witness)

6.6 SPECIAL WITNESS REQUIREMENT FOR RESIDENTS OF SKILLED NURSING FACILITIES

The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

Statement of Patient Advocate or Ombudsman

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

DATED:_____

_____ _____

(Sign your name) (Address)

_____ _____

(Print your name) (City/State/Zip Code)